Olive Branch Psychiatry
New Patient Questionnaire

Please complete these forms and bring them with you to your initial appointment or scan and email to: info@olivebranchpsychiatry.net

Name ______________________________ Date ______________

Date of Birth ____________ Age _____ Gender ☐ Male ☐ Female ☐ Other:_________

Primary Phone ____________________ Secondary Phone ____________________

Email ______________________ Handedness ☐ Right-handed ☐ Left-handed

Address ____

Contact Person ____________________________ ☐ Contact in emergency only

Relationship ____________________________

Primary Phone ____________________ Secondary Phone ____________________

Ethnicity
☐ White ☐ Asian ☐ Native American/Alaskan Native
☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Pacific Islander
☐ Other:______________________________

Referring Physician Information
Were you referred to Olive Branch Psychiatry by another provider? ☐ Yes ☐ No
If yes, please complete the following:
Referring provider name ____________________ Specialty ______________
Address ____
Phone ________________________ Fax ________________________

Primary Care Physician Information
Do you have a Primary Care Physician ? ☐ Yes ☐ No

Name of primary care physician ____________________ Specialty ______________
Address ____
Phone ________________________ Fax ________________________

Clinical Information
Reason for evaluation ____

Olive Branch Psychiatry, LLC
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Allergies to medication/foods and type of reaction ______________________________

Has there been any change in your general health within the last year? ☐ Yes ☐ No

If yes, please describe ______________________________

Have you had any of the following diseases? / **Are you under a doctor's care for this problem?**

	Yes	No	Describe	Yes	No
Emphysema	___	___	______________	___	___
Asthma	___	___	______________	___	___
TB	___	___	______________	___	___
Hypertension	___	___	______________	___	___
Heart Disease	___	___	______________	___	___
Head Injury with Loss of Consciousness	___	___	______________	___	___
Diabetes	___	___	______________	___	___
Thyroid Disease	___	___	______________	___	___
Kidney Disease	___	___	______________	___	___
Sexually Transmitted Disease	___	___	______________	___	___
Glaucoma	___	___	______________	___	___

Nutritional Assessment

Do any of the following apply to you?	Yes	No
I eat less than two meals a day	___	___
My diet has changed over the last 3 months	___	___
I have lost or gained weight in the last 6 months without trying	___	___

If yes, how much? _________________

If yes to any of the above, please describe ______________________________

Do you have specific religious or cultural practices that may affect your treatment? Please describe:

Current Medications & Herbal Treatments

Name	Dose	Date Started	Reason Taking

For Women Only

Date of last menstrual cycle ____________________

Chance of being pregnant ☐ None ☐ Possible ☐ Definite

Number of pregnancies ________

Worsening psychiatric symptoms during or after pregnancy? ☐ Yes ☐ No ☐ N/A

Medical Conditions

Diagnosis	Date Identified	Treatment

Past Surgeries

Procedure	Date	Hospital	Outcome

Past Medical Hospitalizations

Hospital	Dates Inpatient	Reason for Admission	Outcome

Past Psychiatric Hospitalizations

Hospital	Dates Inpatient	Reason for Admission	Outcome

Past Suicide Attempts Number ______

Date	Method	Hospitalized (Y/N)	Outcome

Current Psychiatric Diagnosis (include month/year diagnosed):

____

____

Past Psychiatric Diagnosis (include month/year diagnosed):

____

____

Psychotherapy

Clinician	Type of Therapy	Started	Stopped	Outcome

Previous Psychiatric Medications

Medication	Ever Taken?		Dose	Duration	Helpful?		
Citalopram or CELEXA	Yes	No	_____	_______	Yes	No	Some
Escitalopram or LEXAPRO	Yes	No	_____	_______	Yes	No	Some
Fluoxetine or PROZAC, SARAFEM	Yes	No	_____	_______	Yes	No	Some
Fluvoxamine or LUVOX	Yes	No	_____	_______	Yes	No	Some
Paroxetine or PAXIL	Yes	No	_____	_______	Yes	No	Some
Paroxetine CR or PAXIL CR	Yes	No	_____	_______	Yes	No	Some
Sertaline or ZOLOFT	Yes	No	_____	_______	Yes	No	Some
Desvenlafaxine or PRISTIQ	Yes	No	_____	_______	Yes	No	Some
Duloxetine or CYMBALTA	Yes	No	_____	_______	Yes	No	Some
Milnacipran or SAVELLA, IXEL	Yes	No	_____	_______	Yes	No	Some
Venlafaxine XR or EFFEXOR XR	Yes	No	_____	_______	Yes	No	Some
Bupropion or WELLBUTRIN, ZYBAN	Yes	No	_____	_______	Yes	No	Some
Mirtazapine or REMERON	Yes	No	_____	_______	Yes	No	Some
Nefazodone or SERZONE	Yes	No	_____	_______	Yes	No	Some
Nomifensine or MERITAL	Yes	No	_____	_______	Yes	No	Some
Trazodone or DESYREL	Yes	No	_____	_______	Yes	No	Some
Vilazodone or VIIBRYD	Yes	No	_____	_______	Yes	No	Some
Amitriptyline or ELAVIL	Yes	No	_____	_______	Yes	No	Some
Amoxapine or MOXADIL	Yes	No	_____	_______	Yes	No	Some
Clomipramine or ANAFRAMIL	Yes	No	_____	_______	Yes	No	Some
Desipramine or NORPRAMINE	Yes	No	_____	_______	Yes	No	Some
Doxepin or SINEQUAN, SILENOR	Yes	No	_____	_______	Yes	No	Some
Imipramine or TOFRANIL	Yes	No	_____	_______	Yes	No	Some
Maprotiline or LUDIOMIL	Yes	No	_____	_______	Yes	No	Some
Nortriptyline or PAMELOR	Yes	No	_____	_______	Yes	No	Some
Protriptyline or VIVACTIL	Yes	No	_____	_______	Yes	No	Some
Trimipramine or SURMONTIL	Yes	No	_____	_______	Yes	No	Some
Isocarboxazid or MARPLAN	Yes	No	_____	_______	Yes	No	Some
Tranylcypromine or PARNATE	Yes	No	_____	_______	Yes	No	Some
Phenelzine or NARDIL	Yes	No	_____	_______	Yes	No	Some
Selegiline or Emsam	Yes	No	_____	_______	Yes	No	Some
Carbamezapine or TEGRETOL	Yes	No	_____	_______	Yes	No	Some
Lamotrigine or LAMICTAL	Yes	No	_____	_______	Yes	No	Some
Lithium or LITHOBID	Yes	No	_____	_______	Yes	No	Some
Topiramate or TOPAMAX	Yes	No	_____	_______	Yes	No	Some
Valproic Acid or DEPAKOTE	Yes	No	_____	_______	Yes	No	Some
Aripiprazole or ABILIFY	Yes	No	_____	_______	Yes	No	Some
Asenapine or SAPHRIS	Yes	No			Yes	No	Some
Clozapine or CLOZARIL	Yes	No	_____	_______	Yes	No	Some
Iloperidone or FANAPT	Yes	No	_____	_______	Yes	No	Some
Quetiapine or SEROQUEL	Yes	No	_____	_______	Yes	No	Some
Olanzapine or ZYPREXA	Yes	No	_____	_______	Yes	No	Some
SYMBYAX	Yes	No	_____	_______	Yes	No	Some
Paliperidone or INVEGA	Yes	No	_____	_______	Yes	No	Some
Risperidone or RISPERDAL	Yes	No	_____	_______	Yes	No	Some
Ziprasidone or GEODON	Yes	No	_____	_______	Yes	No	Some
Alprazolam or XANAX	Yes	No	_____	_______	Yes	No	Some
Chlordiazepoxide or LIBRIUM	Yes	No	_____	_______	Yes	No	Some

Medication	Ever Taken?		Dose	Duration	Helpful?		
Clonazepam or KLONOPIN	Yes	No	_____	_______	Yes	No	Some
Diazepam or VALIUM	Yes	No			Yes	No	Some
Lorazepam or ATIVAN	Yes	No	_____	_______	Yes	No	Some
Temazepam or RESTORIL	Yes	No	_____	_______	Yes	No	Some
Buspirone or BUSPAR	Yes	No	_____	_______	Yes	No	Some
Liothyronine or CTOMEL, T3	Yes	No	_____	_______	Yes	No	Some
Modafinil or PROVIGIL	Yes	No	_____	_______	Yes	No	Some
Pemoline or CYLERT	Yes	No	_____	_______	Yes	No	Some
Pindolol or VISKEN	Yes	No	_____	_______	Yes	No	Some
Pramipexole or MIRAPEX	Yes	No	_____	_______	Yes	No	Some
Prazosin or MINIPRESS	Yes	No	_____	_______	Yes	No	Some
Dexmethylphenidate or FOCALIN	Yes	No			Yes	No	Some
Methylphenidate or RITALIN	Yes	No	_____	_______	Yes	No	Some
Methylphenidate XR or CONCERTA	Yes	No	_____	_______	Yes	No	Some
Amphetamine or ADDERALL	Yes	No	_____	_______	Yes	No	Some
Dextroamphetamine or DEXEDRINE	Yes	No	_____	_______	Yes	No	Some
Dextromethamphetamine or DESOXYN	Yes	No	_____	_______	Yes	No	Some
Lisdexamphetamine or VYVANSE	Yes	No	_____	_______	Yes	No	Some

Other Psychiatric Medications	**Reason for Taking**	**Dose**	**Duration**

Previous Brain Stimulation (ECT, rTMS, VNS, DBS, tDCS, EpCS):

Treatment	Facility	Date	No. of Treatments	Outcome (improvement/ side effects)

Social History

Marital Status
- ☐ Single
- ☐ Married _____ time(s) on date(s) ____________________
- ☐ Divorced _____ time(s) on date(s) ____________________
- ☐ Widowed _____ time(s) on date(s) ____________________

Children ☐ No ☐ Yes, number: _______ ages: ____________________

Siblings (brothers/sisters) ☐ No ☐ Yes, ages: ____________________

Education Years of Schooling _____(e.g., graduate high school = 12 years)
Degrees Obtained ______________________________

Current Occupation

Position Date Started

____

____

Previous Occupations

Position Date Started Date Stopped Reason Stopped

____

____

Current Living Situation ____

Weapons in the Home? ☐ No ☐ Yes (type) ______________________________

Do you exercise? ☐ No ☐ Yes

What is the form of exercise, how many times a week, and for how many minutes?

____

____

Traumatic Events in Life

Event Date Degree of Impact

____

____

____

____

____

____

Do you use the following?

Tobacco ☐ No ☐ Yes started _________ amount ________ stopped ________

Caffeine ☐ No ☐ Yes started _________ amount ________ stopped ________

Alcohol ☐ No ☐ Yes started _________ amount ________ stopped ________

Withdrawal symptoms? ☐ No ☐ Yes symptoms ______________________

Marijuana ☐ No ☐ Yes started _________ amount ________ stopped ________

Heroin ☐ No ☐ Yes started _________ amount ________ stopped ________

Cocaine ☐ No ☐ Yes started _________ amount ________ stopped ________

Hallucinogens ☐ No ☐ Yes started _________ amount ________ stopped ________

Other ☐ No ☐ Yes started _________ amount ________ stopped ________

Current Source(s) of Stress ____

Arrest or Legal Issues ____

____

Leisure Activities ____

Family History
Does a relative related to you by blood have any of the conditions below? If so, please list the relationship after the diagnosis (no names).

Depression ______________________________
Bipolar Disorder ______________________________
Schizophrenia ______________________________
Anxiety Disorder ______________________________
Social Phobia ______________________________
Post Traumatic Stress Disorder ______________________________
Panic Disorder ______________________________
Eating Disorder (Anorexia or Bulimia) ______________________________
Attention Deficit/Hyperactivity Disorder ______________________________
Dementia/Alzheimer's Disease ______________________________
Alcohol Dependence ______________________________
Drug Dependence ______________________________
Impulse Control Disorder ______________________________
Personality Disorder (e.g., Paranoid, Borderline, Antisocial, Avoidant) ______________________________
Committed Suicide ______________________________
Seizure Disorder ______________________________
Cerebrovascular Disease (e.g., Stroke) ______________________________
Multiple Sclerosis ______________________________
Brain Tumor ______________________________
Other Neurologic Conditions (List) ______________________________

____
Endocrine Disorders ______________________________
Sudden Cardiac Death ______________________________

Please list any questions you would like to ask your provider at Olive Branch Psychiatry:

____
____
____
____
____
____
____

Signature of person completing this form ______________________________ Date ____________

Print name of person completing this form ______________________________